

■ With other people who are disabled

Other:

## **Westford Special Needs Emergency Registry**

Residents with disabilities, chronic conditions, and special healthcare needs

Westford Health Department and Emergency Management maintains a registry for residents of all ages - infants to seniors - who live at home and who have special cognitive, developmental, mental health, sensory and mobility disabilities, chronic conditions, and/or other special healthcare needs. Residents of assisted living or nursing homes already have staff to assist first responders. By participating in the registry, you permit Emergency Management and the Westford Health Department to share your information with local and state emergency responders such as town police and/or fire departments. The registry allows first responders and emergency management officials to plan, prepare for, and respond to the needs of the community in an emergency though assistance cannot be guaranteed.

Instructions: To be included in the Registry, please fill out this form, sign it, and send it to: Westford Health Department, 55 Main St., Westford, MA 01886

If you have questions, please call (978) 692-5509. If you cannot fill out this form on your own, please have a family member, caregiver, or other representative complete the form and submit it on your behalf.

Name*:First Name	Middle Name Last Name
Gender*: □ M □ F Age	Date of Birth*:(MM/DD/YYYY)
PHYSICAL STREET ADDRESS	,
Street*:	Apartment unit/floor:
City/Town:	Zip Code:
MAILING ADDRESS AS RECOGNIZED BY THE US POSTAL SERVICE (I	f different from physical street address)
Street*:	Apartment unit/floor:
City/Town:	Zip Code:
CONTACT INFORMATION (*A phone number is required)	
Home Phone:	Text Only Number:
Cell Phone:	Videophone Number:
Email:	TTY:
EMERGENCY CONTACT	
Name:	Relationship:
Phone:	Email:
LIVING SITUATION	LANGUAGE
I live in Westford (check all that apply to you)	I prefer to communicate in (select one):
☐ Seasonally from: (month) to: (month)	. ,
☐ Year-round	☐ American Sign Language
☐ Split my time between multiple Westford addresses	☐ Spanish
	☐ Chinese
I live in (select one type of housing):	☐ Indian
□ Single Family	☐ French
☐ Apartment floor	☐ Other:
☐ Condo / Duplex / Townhouse	
☐ Mobile Home	RACE Select one:
Other:	- □ White
	☐ African American / Black
I live (check all that apply to you):	☐ Asian
☐ Alone ☐ with Spouse	☐ Hispanic or Latino
☐ With Family / Friends	□ Native Hawaiian / Pacific Islander
☐ With Caregiver	American Indian / Alaskan Native
☐ In a group home operated by:	Other:
☐ In an independent senior living facility / housing	Guiot.

LIFE SUPPORT SYSTEMS Check all that apply to you:	TRANSPORTATION Check all that apply to you:
☐ Oxygen Tanks ☐ BPAP ☐ CPAP	When I leave my home, I most frequently use a(n):
☐ I have spare tanks	□ Personal Vehicle
Oxygen Concentrator	□ Taxi / Car Service
<ul><li>I have battery or generator back up for this</li><li>Respirator / Ventilator</li></ul>	<ul><li>□ Public Bus</li><li>□ LRTA Paratransit Services or COA Van</li></ul>
☐ I have battery or generator back up for this	☐ Wheelchair Van / Bus
☐ Tracheostomy	☐ Ambulance
□ IV line	☐ Bicycle
☐ Urinary Catheters	Other:
□ Colostomy / Ileostomy	
□ Feeding Tube □ Suction	If I need to evacuate, I would be accompanied by: ☐ No one
☐ I have battery or generator back up for this	☐ Caregiver
☐ Dialysis at a clinic	☐ Family / Friend
☐ Dialysis at home	□ Other:
☐ I have battery or generator back up for this	ACCICTANCE DECLUBED
□ Pacemaker	ASSISTANCE REQUIRED Check all that apply to you:
□ Defribillator	On a normal day, I require assistance with:
Other Electrical Needs:	□ Feeding myself
☐ None of the above	☐ Taking medication(s)
SENSORY Check all that apply to you:	Communicating to others     Assistive Technology   Luce:
	□ Assistive Technology - I use: □ Transportation
☐ Hard of Hearing ☐ Visually Impaired	☐ Using the toilet
☐ Use of Hearing Aid(s) ☐ Legally Blind ☐ Glasses	☐ Dressing / Undressing
☐ Use of Cochlear Implant(s) ☐ None of the Above	☐ Bathing / Grooming
	<ul><li>Dentures</li></ul>
COGNITIVE / PSYCHIATRIC / NEUROLOGICAL / MUSCULAR Check all that apply to you:	☐ Transferring from/to: ☐ Bed ☐ Wheelchair ☐ Toilet ☐ Shower / Tb  Other Assistance:
□ Seizure Disorder □ Depression	☐ I use a service animal
☐ Speech Impaired ☐ Anxiety	☐ I require supervision
□ Non-verbal □ Bipolar Disorder	☐ I receive medical treatment(s) from a nurse / doctor at home
□ Cognitively/ □ Schizophrenia	☐ I receive medical treatment(s) at a healthcare facility at least once a
developmentally delayed   Post-traumatic Stress Disorder	week
☐ Autism Spectrum Disorder (PTSD)	Other:
□ Alzheimer's / Dementia □ Obsessive Compulsive Disorder	□ None of the above
□ Parkinson's (OCD) □ Cerebral Palsy □ Other:	PETS
☐ Multiple Sclerosis ☐ None of the Above	☐ I use a service animal
	☐ I have a pet
MOBILITY Check all that apply to you:	☐ I would be taking my pet if I needed to go to a shelter
☐ Use a wheelchair / mobility vehicle	□ Other assistance:
☐ Wheelchair / mobility vehicle is power dependent	OTHER DISABILITIES / CONDITIONS
☐ I have battery or generator back up for this	
☐ Use walker / cane	□ Diabetes □ Allergies:
☐ Use crutches	☐ I use Insulin
☐ Use prosthesis (specify prosthesis):	☐ I weigh between 300 and 549 lbs☐ I weigh between 350 and 799 lbs
☐ Confined to a bed	☐ I weigh 800 lbs or greater
<ul><li>Bed is power dependent</li><li>I have battery or generator back up for this</li></ul>	Please list other disabilities or relevant conditions:
Other:	
□ None of the Above	
emergency responders and/or public health agencies. I also understart departments or officials may share this information in order to better assistance.	I information and other information to be shared with federal, local and state and that this is a voluntary program and while the Town of Westford and or its st me during an emergency, the Town of Westford and its employees, officials or assistance are being provided in relation to my participation in this program.
Signature:	
Print Name:	Date:

If you are completing this form on someone's behalf, please indicate your name and relationship to that individual:

Date: \_\_\_

Print Name: \_\_\_